

New perspectives on health inequalities

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Our vision is for Wales to be a nation where everyone has a decent standard of living, a healthy and fulfilled life, and a voice in the decisions that affect them.

As an independent, registered charity, the Bevan Foundation relies on the generosity of individuals and organisations for its work.

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Introduction

Health inequalities have long been a focus of public policy, both in Wales and elsewhere. Macmillan Cancer Support and the Bevan Foundation share a concern that the gaps in health between rich and poor show few signs of closing, despite significant public spending on the NHS and public health in Wales.

We recognise the commitment of many health care providers to reducing health inequalities and their achievements to date. Nevertheless, with most health gaps persisting and some widening we felt it was timely to discuss what more and what else could be done.

To that end, we brought together 25 people from a range of civil society, government and professional organisations to a seminar on 23rd October 2018. The seminar began with a presentation by Dr Graham Moore, Reader in Social Sciences and Health, and Deputy Director, DECIPHER, at Cardiff University. Groups then discussed the following questions and reported back:

1. Are there any groups of people who experience inequalities in health that are not recognised or considered in public policy?
2. Are there any health conditions / diseases with unequal prevalence about which there should be more evidence?
3. What more do we need to know about 'what works' in reducing health inequalities?
4. Are there any other aspects of health inequalities that you would like to be included in public policy?

This short paper aims to summarise the general views of participants rather than capture every detailed point made. Inevitably not every contribution has been included, but we hope that where there were differences of view or emphasis that it is made clear.

In general we found a universal concern about health inequalities, an appetite for more and better evidence and a desire for urgent and radical action. This is a solid building block for a future in which everyone's health improves, but in which we also – finally – make significant progress on Wales' substantial health gap. We hope this short note helps to set that agenda.

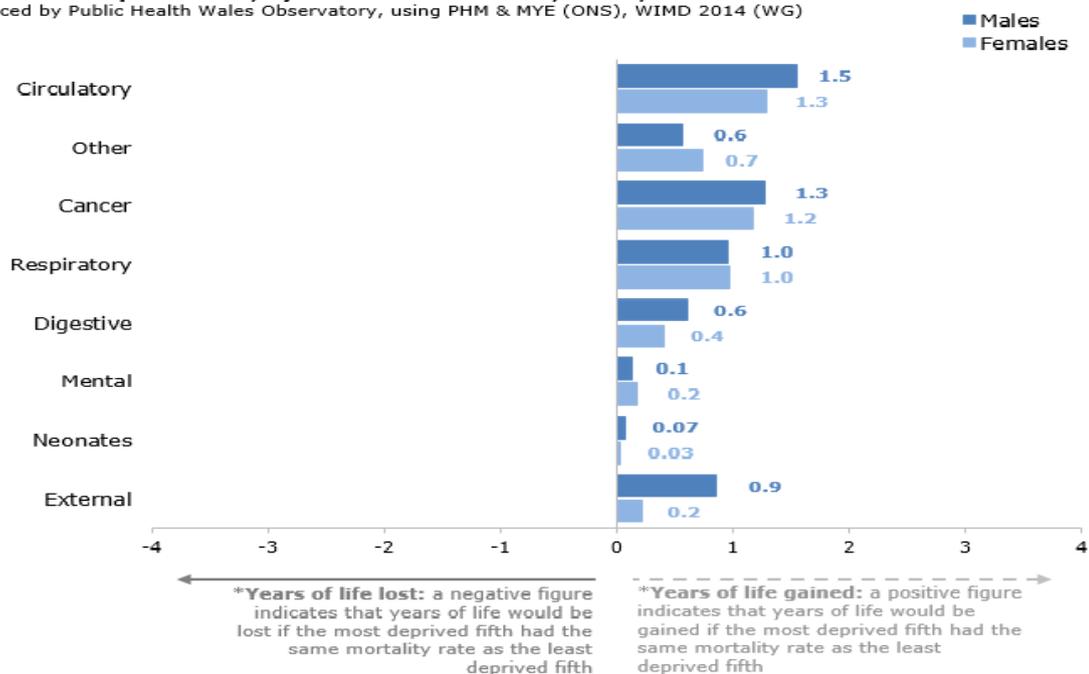
Health inequalities in Wales today

Health inequalities in Wales remain a major challenge. The gap in life expectancy between the most or least affluent deprivation quintiles in 2014 was approximately 7 years for women and 9 years for men. Poorer groups live a substantially smaller proportion of their already shorter lives in good health - almost 20 fewer 'healthy' years than the most affluent quintile. And while life expectancy overall is increasing, the gap in life expectancy between males living in the most and least deprived areas has not changed significantly.¹

The impact of a greater disease burden on people from the most deprived fifth of places is clear in Figure 1 below. If the mortality rate from circulatory disease in the most deprived areas was the same as that in the least deprived, life expectancy would increase by 1.5 years. For cancer, the increase in life expectancy would be 1.3 years, and for respiratory diseases, the increase would be 1.0 years.

Figure 1

Years of life expectancy gained or lost* if the most deprived fifth had the same mortality rates as the least deprived fifth, by broad cause of death, Wales, 2012-2014
 Produced by Public Health Wales Observatory, using PHM & MYE (ONS), WIMD 2014 (WG)



Source: Public Health Wales (2016) **Measuring inequalities 2016: trends in mortality and life expectancy in Wales**. Available at: www.publichealthwalesobservatory.wales.nhs.uk/inequalities

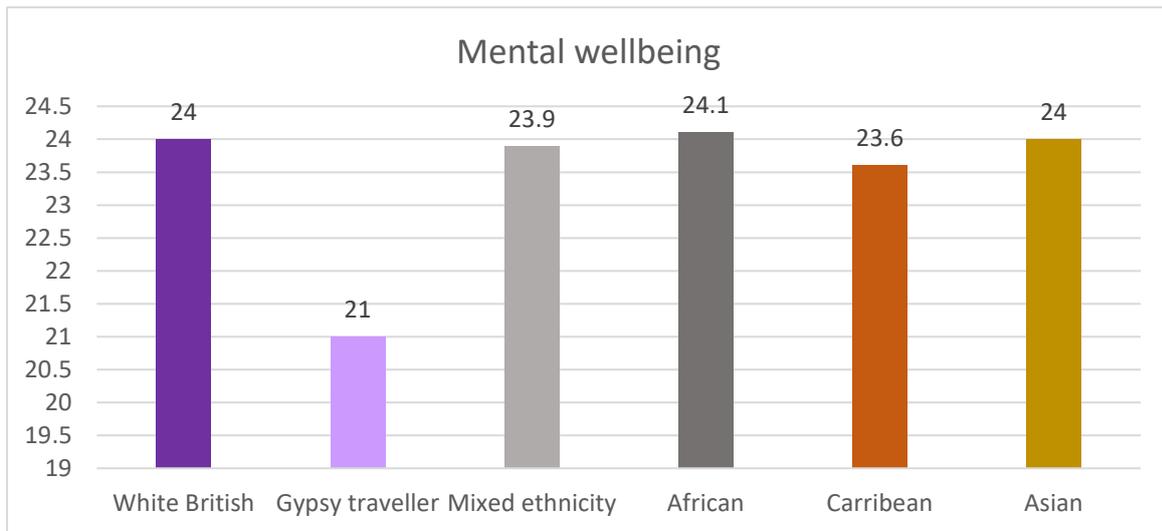
In discussion, participants recognised that deprivation is one of the biggest drivers of health inequalities. However, many participants suggested that consideration of deprivation should be more nuanced. In particular, measuring health inequalities through area-based deprivation was felt to result in interventions in the most deprived quintile of places. One effect of this approach is to exclude the majority of people of low-incomes from area-based actions, as not all people experiencing poverty and disadvantage live in deprived areas. This is not a new issue – Dr Moore reminded delegates that in 2010 Marmot had concluded that:

‘health inequalities operate on a graded continuum not in a binary manner’.

While participants acknowledged the importance of deprivation they also stressed that there were other important inequalities that should be taken into account. Characteristics protected by the Equality Act 2010, such as gender, disability, ethnicity and sexual orientation or gender identity, were considered by many to be vitally important to health outcomes yet these are often not recognised sufficiently. Participants were not suggesting that biological differences associated with sex or age, for example, should be ignored but that the different social relationships experienced by different groups did make a difference. For example, while differences in women’s heart health relative to men’s are recognised, women’s outcomes are far worse than would be expected.

This point was ably illustrated by figures on mental wellbeing (Figure 2) which show that gypsy travellers and to a lesser extent people of Caribbean ethnicity have lower mental wellbeing scores than White British people.

Figure 2 Mental wellbeing by ethnic group



Source: G. Moore, Presentation to seminar, 23rd October 2018

It was suggested that having a ‘protected characteristic’ could compound the impact of low income. Participants gave numerous examples of inequities associated with disability and gender. One explained that not only do many disabled people have a low income but they also have additional costs of living associated with their disability or health condition, e.g. extra heating or travel costs, or costs of special diets. For example, cancer is considered a disability from the point of diagnosis: the hidden cost of cancer can lead people to make decisions about attending hospital or eating that are not in their best interests. Another participant noted that people with learning disabilities often have a low income and can also find it more difficult to access and comply with appropriate treatment for any health conditions they may have. Similarly it was pointed out that women on low incomes had to bear the cost of sanitary products from their limited resources which men on low incomes did not.

It was also suggested that the experience of living in deprivation varies considerably for different groups of people and also has different impacts. Participants were particularly concerned about the effects of deprivation on children and young people’s health. Dr Moore illustrated this point by explaining that about 50 per cent of young people from the poorest households live with a parent who smokes, five times higher than in the most affluent families. Children from the poorest households are more likely to take up smoking and are less likely to quit successfully as adults.

The relationship between income inequalities and other inequalities was hotly contested. Some participants suggested that having an adequate income enabled individuals to overcome inequalities linked with their personal characteristics, but by no means everyone agreed. Others pointed out that understanding that the population in deprived areas can have diverse characteristics is crucial to a deeper understanding of health inequalities and to inform action to reach different groups of people in deprived areas.

It was also noted that Public Health Wales is bound by the Equalities Act 2010 Public Sector Equality Duty, which requires organisations to ‘advance equality of opportunity between people who share a relevant protected characteristic and those who do not’ in exercising its functions. Recognising that diversity cuts across deprivation is therefore a statutory duty.

Some participants felt that consideration of health inequalities was too driven by quantitative data. There was a risk of small groups of people being hidden by big numbers, rendering them invisible. The example of homeless people was given – they have unique experiences which are not captured by ‘deprivation quintiles’. The reliance on quantitative data also means that people’s health experiences or stories, about what really mattered to them, are marginalised.

In addition, it was suggested that the focus is very much on life expectancy and that other measures of inequality, such as quality of life, inequalities in different health conditions or in accessing services, received far less attention. Life expectancy is simply too high-level a measure to enable progress to be monitored - it can take a generation to change and so intermediate measures of change need to be introduced to enable change to be tracked. Life expectancy is not necessarily what matters to people – it is their ability to live a meaningful life. While the use of statistics on healthy life expectancy partly addresses this issue, participants felt that more could be done to understand the determinants of patient experience and quality of life. This is of growing importance as survival from diseases like cancer increases.

One suggestion was to use ‘red flag’ indicators, which should include ‘soft’ measures of people’s well-being as well as other measures. Red flag indicators would highlight where health improvement programmes may not be reaching specific groups of people. For example, while the proportion of all adults aged 16 and over who smoke is 19 per cent, the proportion of adults who smoke in the most deprived areas of Wales is 28 per cent.

The discussion suggested that consideration of health inequalities should be wider, and include:

- **A number of socio-economic factors, not just area deprivation.**
- **Protected characteristics of gender, age, disability, race and sexual orientation as well as sub-groups such as carers, homeless people and young people in care.**
- **Use of standard indicators of equity in prevalence of specific diseases and access to services, to enable progress to be tracked.**
- **Use of wider measures of health equality – such as quality of life and patient experience.**

Evidence gaps

There was a wide-ranging discussion about any health conditions / diseases with unequal prevalence about which there should be more evidence, and marked differences of view.

Some participants considered that there is sufficient evidence about the majority of health conditions and their relationship with deprivation and other inequalities. The real problem is the lack of action to address them, possibly because there is not enough evidence about the return on investment.

Other participants suggested that there are significant evidence gaps. One of the areas identified was evidence on presentation, testing and diagnosis of conditions including cancer. For example, there are differences in awareness of symptoms and in the uptake of screening which can be contributory factors to inequalities in life expectancy, yet there is limited knowledge about these issues. Similarly, it was pointed out that different groups of people have different expectations about their own health which can have a profound impact on health behaviours and ability to self-care. Several participants pointed out that issues around access to health care, including rural-urban dimensions, were also less well-understood than they should be.

It was noted that many programmes could be evaluated better, with impact on equality being explicitly included. Evidence should be more effectively collated and most importantly, evidence should be used to inform decisions. Some participants suggested that activity was sometimes funded because it was easy and grabbed headlines rather than because it worked. Where no 'off-the-shelf' solution exists, policy-makers and health professionals should be willing to innovate.

Others suggested that there were gaps in evidence about inequalities in specific conditions and in particular that there continued to be a lack of information about the major causes of inequalities in life expectancy including heart disease, cancer, respiratory disease, obesity and alcohol misuse.

The discussions indicate that there is no shared view about the adequacy of evidence or otherwise. This may reflect differences in participants' remit as well as the accessibility of evidence and its synthesis into easily-understood and unambiguous guides. Further work to identify gaps in evidence on health inequality in the causes, diagnosis, treatment and recovery from specific diseases may therefore be useful.

What works?

There were similarly wide-ranging discussions about 'what works' to reduce health inequalities. Some participants felt that the evidence base on effective interventions in respect of most health inequalities is relatively good, with there being a sound basis for action to reduce take up and encourage quitting of smoking, and to improve diet and exercise, and reduce alcohol consumption.

However, some participants suggested that although the evidence-base may be strong in respect of the health of the population as a whole, it did not necessarily take into account the realities of people's lives on low incomes. Dr Moore pointed out that with some exceptions (e.g. fiscal approaches), intervention on smoking has been disproportionately effective in more affluent groups. Other examples were given of an individual who had been included in an exercise referral programme by his GP but was unable to afford the £3.30 return bus fare to the gym. Another participant pointed to advice on self-care, which was 'one-size-fits-all' without taking into account people's circumstances e.g. if they were a carer, from a black or minority ethnic community or unable to understand the advice given.

More generally, many participants noted that many public health interventions to reduce inequalities are based on individuals changing their behaviour. Dr Moore questioned whether seeing unhealthy behaviours such as smoking or eating sugary foods as 'lifestyle choices' was helpful. He suggested that instead these are 'social practices' which cluster within groups due to shared social conditions, with behaviours reflecting deeper problems. At worst, the emphasis on 'lifestyle' means people are blamed for their own ill-health and attention is distracted from the need for more radical action.

In addition, some participants questioned the effectiveness of some public health programmes on reducing health inequalities: for example, only 1.1 per cent of Wales' smokers participated in Stop Smoking Wales in 2017/18, with less than half of participants succeeding in quitting. While supporting an estimated 2,500 people to quit an exceptionally difficult habit to break is welcome, it is not delivering the transformation that many would like. There was some discussion about whether the focus should shift to tackling the root causes of unhealthy behaviours, such as a shortage of jobs, poverty, poor quality and insecure housing and over-stretched social care.

Moore pointed to policies that could change the immediate environment of unhealthy behaviours, aiming to make it more expensive or more difficult to undertake. He noted the ‘layering’ of actions against smoking, the Minimum Unit Pricing of alcohol and UK-wide sugar tax which aims to reformulate soft drinks and change in consumer behaviour as examples. Understanding how these universal policies affect people on low incomes will be key.

In discussion, a number of participants suggested a different approach to reducing health inequalities rather than the conventional focus on changing people’s behaviour. As an alternative, participants discussed a ‘whole person’ approach, which would include addressing mental as well as physical health and would embrace social factors such as loneliness and isolation as well as attempting to change health-related behaviours such as smoking. This whole-person approach could be adopted around the time of diagnosis of a long-term health condition. However, some participants suggested that people on low incomes or with some protected characteristics have low expectations of their own health and wellbeing that would need to be taken into account.

Moore outlined the advantages and disadvantages of targeted approaches, such as Flying Start and the School Holiday Enrichment Programme, alongside universal programmes such as Free School Breakfasts. The dilemma of universal vs targeted provision prompted a lively debate, with the idea of ‘progressive universalism’ – in which a service is available to all but is enhanced for specific groups or places – generating a lot of interest.

Looking at mechanisms for change, Moore suggested that schools are a potential vehicle for reducing the transmission of inequalities between generations, although there were limits to how much schools could achieve alone. He also said that the relationships between health and many other services were also important.

Some participants suggested that there should be a stronger emphasis on end-of-life care, with health professionals being encouraged to discuss quality of life with people. One participant suggested a ‘Last 1,000 days’ programme which would parallel the Welsh Governments’ ‘First 1,000 days’ programme. Others suggested a focus on reducing known risk-factors for poor health. For example, living in damp or overcrowded housing is strongly associated, through well-understood mechanisms, with a range of conditions from respiratory difficulties and allergies to poor mental health. Similarly, being a carer is associated with poorer mental health, stress-related illness such as high blood pressure and physical injury associated with heavy lifting.

Moore set the scene for discussion about the social determinants of health, by pointing out that health inequalities stem from economic inequalities. He quoted Lynch et al (1977):

“Efforts to reduce socio-economic inequalities in health must recognize that economic policy is public health policy.”

He commented that while it is probably not possible to eliminate health inequalities without confronting the economic systems which perpetuate them, ‘recognising that we can’t do everything is not an excuse for doing nothing’. The Wellbeing of Future Generations Act and the Social Services and Wellbeing Act both provide a valuable framework within which social determinants of health can be addressed. Participants showed some appetite for a more radical approach to changing the economic system, although it was acknowledged that such change would not be easy.

There were differences of view about the availability and quality of evidence on ‘what works’, suggesting that accessible summaries of what is available might be useful. Most participants favoured reducing wider social and economic inequalities, including specific measures to address known risks to health. In terms of changing behaviours, there was some enthusiasm for ‘equity-sensitive universal’ programmes over those based on deprived areas, as well as many ideas for wider action.

Conclusion and next steps

Inequalities in health are a major challenge for Wales. Although usually conceived of in terms of deprivation, there is strong interest in a wider view of inequality which encompasses socio-economic characteristics, protected characteristics and small, often high-risk, groups of people. There is also a keen interest in developing alternative measures of inequality to life expectancy, which would be more meaningful to people and easier to track.

There are differences of view about the availability of evidence on causes of inequalities and effective interventions. At the very least, this suggests that existing evidence needs to be more accessible and unambiguous for professionals in fields other than public health. Where there are gaps in evidence, there was a clear demand for gaps to be filled, for greater innovation in practice and for effective dissemination.

Looking at action, it was recognised that the current approach, based on a mix of population-wide changes in policy and targeted programmes to change behaviour, is deliverable. However, participants felt that action does not always reach people in lower socio-economic groups or with certain protected characteristics, especially at a scale sufficient to make a difference. There was a call for a greater political commitment to reducing wider social and economic inequalities and for closer liaison between those concerned about public health and those responsible for other services such as housing, the economy and environment.

Macmillan Cancer Care and the Bevan Foundation plan to work together to develop and take forward the agenda on health inequalities, to improve the quality of life of everyone in Wales.

¹ The gap in life expectancy for males has fallen by 0.3 years and for females increased by 0.1 years, from 2005-09 to 2010-14. The changes are within the margin of statistical error. (Public Health Wales, Inequalities in Life Expectancy data at <http://www.publichealthwalesobservatory.wales.nhs.uk/measuring-inequalities-2016-files>)